Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JAMES T ROBISON
5656 BEE CAVE RD STE M-301
AUSTIN TX 78746

Respondent Name
Service Lloyds Insurance Co

Carrier's Austin Representative
Box Number 01

MFDR Tracking Number
M4-13-1881-01

MFDR Date Received
March 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the explanation of benefits, two out of the four CPT Codes 20670 were denied payment and bundled."

Amount in Dispute: $2,821.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement was awarded for each anatomical site. This is in accordance with the correct coding initiatives and Rule 134.403."

Response Submitted by: White Espey, P.O. Box 152949, Austin, TX 78715

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2012	Surgical Procedures	$2,821.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 51 – Multiple Procedure
   - 58 – Staged or Related Procedure
   - 97 – Charge Included in another Charge or Service
   - W1 – Workers' Compensation State Fee Schedule Adj
   - 193 – Original payment decision maintained

Issues

1. Did the respondent support the insurance carrier's reason for denying disputed services?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed services with reason code 97 – "Charge Included in another Charge or Service". Review of the "OPERATIVE REPORT" dated 11-26-12, indicates:

   i. removal of "pins" there is only indication of "wound".

   Previous "OPERATIVE REPORT" dated 10/18/2012 indicates:

   i. procedure performed on middle and ring finger.

   28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing, reporting and reimbursement of professional medical service, Texas Workers' Compensation participants shall apply the following: (1) Medicare payment policies, including its coding; billing; …and other payment policies in effect on the date a service is provided…" The disputed service code 20670 is described per AMA CPT code as; "Removal of implant; superficial (eg. Buried wire, pin or rod) (separate procedure). The insurance carrier allowed for two procedures and denied two procedures. Review of the submitted documentation finds the carrier's denial reason is supported as only one incision on each finger is documented. Therefore, this service will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2012, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-facility Price or:

Code	MAR Calculation	Units	Allowable
20670	(54.86 / 34.0376) x 388.68	1	$626.45
20670	(54.86 / 34.0376) x 194.24 (multiple procedure subject to 50% reduction)	1	$313.07
		Total	$939.52

3. The total allowable for the disputed services is $939.52. The carrier paid $939.63. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 25, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received

by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.